MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12165

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:
County: Cecil
City or town: St Augustine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: St Augustine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James John. Adams | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-9-1903

8. AGE: Years	Months	Days	If less than one day
42	3	5	hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation: Farm Hand
11. Industry or business

FATHER
12. Name: No
13. Birthplace: Information

MOTHER
14. Maiden name: "
15. Birthplace

16. Informant: Mr Henry Davis
Address: St Augustine, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22, 45 (month) (day) (year)
Cemetery or crematory: Country
Location: Cherry Hill Md
18. Funeral director: H. W. Lippin
Address: Elkton, Md

19. 12/22/45 (Date rec'd by registrar) Mrs. Ralph H. Rees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1945 at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Strangulation	
Hanging.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 12-14-45
Where did injury occur? St Augustine (City or town) Cecil (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Injured at work?

23. SIGNATURE: Ralph Rees M.D.
Address: Rising Sun Md M. D. or other
Date signed 12-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122a)

CERTIFICATE OF DEATH

12166

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, Institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 1 wk

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: J. Howard Ash

3.(b) Social Security Number: 717-09-2552

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Eva L Ash
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Dec 8 1885

8. AGE: Years	Months	Days	If less than one day
60		19	hrs. min.

9. Birthplace: Elkton Cecil Maryland (Town, county, and state)
10. Usual occupation: Railroad Operator
11. Industry or business: Penn R R Co

FATHER
12. Name: Stephen O Ash
13. Birthplace: Glasgow Delaware

MOTHER
14. Maiden name: Susan McLear
15. Birthplace: Wilmington Del

16. Informant: Mrs Eva L Ash
Address: 130 moffit St Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 31 1945 (month) (day) (year)
Cemetery or crematory: Elkton Cemetery
Location: Elkton Md

18. Funeral director: H. W. Tippin
Address: Elkton Md

19. Dec 29 1945 (Date rec'd by registrar) F H Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20 1945 to Dec 27 1945 and that I last saw h..in alive on December 27 1945

Immediate cause of death	DURATION
Strangulated hernia	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

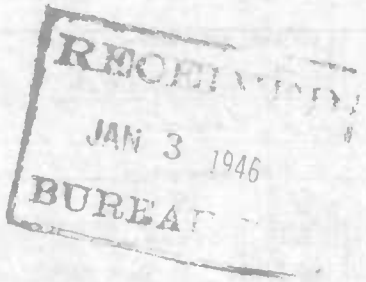
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. T. Morrison, M.D. M. D. or other
Address: Elkton, Md Date signed: 12-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


JAN 3 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12167

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months 8 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: —

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1612 - 5th Street, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American ✓

3.(a) FULL NAME: ATKINSON, CHARLES S.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 11, 1876

8. AGE: Years	Months	Days	If less than one day
69	4	2	___ hrs. ___ min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER
12. Name: Edward S. Atkinson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary Over
15. Birthplace: Washington, D.C.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-15-45 (month) (day) (year)
Arlington Nat.
Cemetery or crematory
Fort Myer, Va.
Location

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Dec. 15 1945 (Date rec'd by registrar) Irene E. Dingle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1945, at 7:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5 1945, to December 13 1945 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Syphilis of the Central Nervous System, xxxxxxxxxxxxxxxxxx	
Due to: xxx type tabo-paretic	Undetermined
Arteriosclerosis, general and	
Due to: xxx coronary	Undetermined
Other conditions: Psychosis with syphilis of central nervous system, tabo-paresis (Include pregnancy within 3 months of death)	Over 10 mo.

Major findings of operations: —

Same as above — Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, Lt. Col., M.C. or other (M.D.)
Address: Clinical Director, Veterans Administration, Perry Point, Md.
Date signed: 12-13-45

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Diat. No. 12168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 mo. 9 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 1 yr. 1 mo. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1725 Druid Hill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: BAILEY, James H.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): November 21, 1893

8. AGE:

Years	Months	Days	If less than one day
52	1	1	... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER — 12. Name: Rand Bailey; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Martha Burkess; 15. Birthplace: Virginia

16. Informant: Records - Veterans Adm. Hospital
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: December 26, 1945 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Mrs. GEORGE H. HOLLAND
Address: 1631 Druid Hill Ave., Baltimore, Md.

19. 12/26/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20, 1945, at 10:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11, 1944, to December 20, 1945 and that I last saw him alive on December 20, 1945

Immediate cause of death	DURATION
Organic Brain Disease	16 yrs.
Due to:	
Due to:	
Other conditions: Psychosis w/organic brain disease	16 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. HOLLINGER, LT. COL., MC M. D. or Coroner

Address: Vets. Adm., Perry Point, Md. Date signed: 12-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

12169

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Bair

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Bair

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	8	...hrs. ...min.

9. Birthplace: Colora, Cecil Co., Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Jacob Bair

13. Birthplace: Germany

MOTHER — 14. Maiden name: Catherine Snyder

15. Birthplace: Germany

16. Informant: Mary Bair

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28, 1945 (mouth) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora, Md. Rural

16. Funeral director: Lee A. Jefferson & Son

Address: Perryville, Md

19. Dec. 28 1945 Irma E. Daugherty, Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945, at 6.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1943, to December 25 1945

and that I last saw him alive on December 25 1945

Immediate cause of death	DURATION
Chronic Valvular Heart Disease	10 yrs
Due to	
Due to	
Other conditions: Chronic Nephritis (Interstitial)	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. F. Magner M. D. or other

Address: Perryville Md Date signed 12/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-A)

CERTIFICATE OF DEATH

12170

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Rural Near Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

Holly Hall Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rural Near Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Holly Hall Farm

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alexius Berger

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1864

8. AGE: Years	Months	Days	If less than one day
81	4	11	..... hrs. ..... min.

9. Birthplace: Swiss (Town, county, and state)

10. Usual occupation: Farm Hand

11. Industry or business

FATHER 12. Name: ?

13. Birthplace

MOTHER 14. Maiden name: Information.

15. Birthplace

16. Informant: Father John W. Schlinkmann

Address: Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 14, 1945 (month) (day) (year)

Cemetery or crematory: Devine Savior Seminary

Location: Lanham, Maryland

18. Funeral director: H. W. Pippin

Address: Elkton, Md.

19. Dec 13 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1945, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10, 1944, to Dec. 11, 1945 and that I last saw him alive on December 11, 1945

Immediate cause of death	DURATION
Myocardial Failure	
Due to: Cardiovascular renal disease.	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr. Leland H. Donaghey, M.D. M. D. or other

Address: Elkton, Maryland Date signed: 12/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12171/6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Seaford, Delaware
(If outside city or town limits, write RURAL and give nearest town)

Street No.: — R.D. #2
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I ✓

3.(a) FULL NAME: BOSMAN, Albert B.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia E. Poholsky

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): January 16, 1895

8. AGE: Years	Months	Days	If less than one day
50	10	28	— hrs. — min.

9. Birthplace: Seaford, Delaware
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: —

FATHER 12. Name: Columbus Bosman

FATHER 13. Birthplace: Seaford, Delaware

MOTHER 14. Maiden name: Jane Arterbridge

MOTHER 15. Birthplace: Seaford, Delaware

18. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-17-1945 (month) (day) (year)

Cemetery or crematory: Odd Fellows

Location: Seaford, Del.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Dec. 15 1945 (Date rec'd by registrar) Irma E. Daughtry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1945 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 3 1945, to December 14 1945

and that I last saw him alive on December 14 1945

Immediate cause of death: Myocardial degeneration — DURATION: Unknown

Due to: Syphilitic Disease of heart — Unknown

Due to: —

Other conditions: Psychosis with syphilis of Central Nervous System. Meningo Encephalitis Type-12 years
(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: E. T. ROLLINGER, Lt. Col., M.C. M. D. or other

Address: Clinical Director, Veterans Administration, Perry Point, Md. Date signed: 12-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

Reg. Dist. No. 12172 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs. 4 mo. 10 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Warren
City or town: Warren
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. I ✓

3.(a) FULL NAME: CLEMENS, Daniel

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 18, 1895

8. AGE: Years 50 | Months 3 | Days 24 | If less than one day: — hrs. — min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal ✓ (Burial, cremation, or removal. Which?) Date thereof: December 12, 1945 (month) (day) (year)
Cemetery or crematory: Warren Cemetery,
Location: Warren, Pennsylvania

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Dec. 12 1945 (Date rec'd by registrar) Registrar: Irma E. Douglas

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1945 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1925 to December 12 1945 and that I last saw him alive on December 12 1945

Immediate cause of death	DURATION
Cancer of the Stomach, lesser curvature	Over 8 months
Due to	
Due to	
Other conditions: Dementia Precox, Catatonic Type	25 years

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: C. E. Trollinger, Lt. Col., M.C. M. D. or other
Address: Perry Point, Md. Clinical Director, Veterans Administration
Date signed: Dec. 13, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

12173

Reg. Dist. No. 9/

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Chesapeake City.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William A. DeShane ~~William A. DeShane~~ William A. DeShane.

3.(b) Social Security Number 168-20-1500

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Bessie W. DeShane

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): March 9 1879

8. AGE:

Years	Months	Days	If less than one day
66	9	16	hrs. min.

9. Birthplace: Cecil Co Md.

(Town, county, and state)

10. Usual occupation: Ferry Deckhand.

11. Industry or business

FATHER

12. Name: Alfred T. DeShane.

13. Birthplace: Cecil Co Md.

MOTHER

14. Maiden name: Jennie Dyer

15. Birthplace: Pennsylvania

16. Informant: Kathleen DeShane

Address: Chesapeake City, Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Dec. 28/45 (month) (day) (year)

Cemetery or crematory: Bethel -

Location: Near Chesapeake City, Md

18. Funeral director: H. Lee Pepper

Address: Elkton, Md.

19. December 26 1945 (Date rec'd by registrar) Jane Bayliss Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1945, at 2206 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Drowned.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 12/25-45

Where did injury occur? Chesapeake City (City or town) Cecil (County) Md (State)

Injured at home, farm, industry, public place (where?): Ches & Del. Canal

Means of injury: Drowned. Injured at work? yes.

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Rear 9 Bow Md Date signed: 12/25-45

12174

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 91

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: Lucy B. Dunsmore

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) If single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Charles T. Dunsmore
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov 15 1859

8. AGE:

Years	Months	Days	If less than one day
86	—	25	... hrs. ... min.

9. Birthplace: Elkton Rural Cecil Co. Md (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Morris Brogan
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Carson
15. Birthplace: Maryland

16. Informant: Charles Henry Dunsmore
Address: Elkton R.D. 5 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-13-45 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Cherry Hill, Md

18. Funeral director: Joseph R. Frame
Address: North East, Md

19. Dec. 13 19 45 (Date rec'd by registrar) Mrs. Ralph Rees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-10-45 19... at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 42, to 12-10-45 19...
and that I last saw h.er alive on 12-10-45, 19...

Immediate cause of death	DURATION
Broncho-pneumonia	3 days
Due to: Bronchitis	2 weeks
Due to: Senility	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Wm. E. VanHorden M. D.
M. D. or other
Address: Box 26 Chesapeake City Date signed 12-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

12175

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 7 mos. 12 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? 5 yrs. 7mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: --

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 215 N. Carrollton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: GREEN, Samuel

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: Separated

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 24, 1895

8. AGE: Years	Months	Days	If less than one day
50	7	29	..... hrs. ..... min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Fisherman

11. Industry or business: Fish

FATHER
12. Name: Unknown - deceased

13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown - deceased

15. Birthplace: Unknown

16. Informant: Records - Veterans Administration

Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-29-1945 (month) (day) (year)

Cemetery or crematory: ANNAPOLIS NATIONAL CEMETERY

Location: Annapolis, Md.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Dec 29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1945 at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1940, to Dec. 22 1945 and that I last saw him alive on December 22 1945

Immediate cause of death	DURATION
Pneumonia, lobar	2 days
Other Diseases:	
Due to Progressive Spinal Muscular Atrophy	45 yrs.
Due to	
Other conditions Mental Deficiency, Moron	Lifetime

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: A. E. Trollinger M.D. or other

Address: Vets. Adm., Perry Point, Md. Date signed 12-22-45

A. E. TROLLINGER, LT.COL., MC, CHIEF DIRECTOR

VS A15 3-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12176

Reg. Diat. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: BAINBRIDGE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 days
Hospital, institution, or street address where death occurred:
USNH, NTC, BAINBRIDGE, MARYLAND
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MASS. County: UNKNOWN
City or town: EVERETT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 SUMMIT AVENUE
(If rural, give LOCATION)
2.(a) If veteran, name war: WORLD WAR II ✓

3. (a) FULL NAME
George McLeod GUILD

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 6 September 1927

8. AGE:	Years	Months	Days	If less than one day
	18	3	2	..... hrs. ..... min.

9. Birthplace: EVERETT, MASS.
(Town, county, and state)

10. Usual occupation: U. S. NAVY

11. Industry or business: U. S. NAVY

FATHER
12. Name: Henry W. GUILD
13. Birthplace: UNKNOWN

MOTHER
14. Maiden name: Audrey C. GUILD
15. Birthplace: UNKNOWN

16. Informant: U. S. NAVAL HOSPITAL, NAV TRA CEN
Address: BAINBRIDGE, MARYLAND.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 10, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Everett, Mass.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Dec. 10 1945 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 DECEMBER 1945 at 10:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 December 1945, to 8 December 1945 and that I last saw him alive on 7 December 1945

	DURATION
Immediate cause of death: ENCEPHALITIS, ACUTE	5 DAYS
Due to: ETIOLOGY UNDETERMINED	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: ENCEPHALITIS ACUTE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

H. C. Oard

23. SIGNATURE: H. C. OARD, CAPTAIN (MC) USNR.
M. D. or other

Address: USNH NTC BAINBRIDGE, MD. Date signed: 12/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12177

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Charlestown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry S. Haines

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Lee Haines
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 1, 1868

8. AGE: Years	Months	Days	If less than one day
77	3	29	hrs. min.

9. Birthplace: Cecil Co., Md. (Town, county, and state)
10. Usual occupation: Telegraph Operator
11. Industry or business: Pa. R.R.

FATHER
12. Name: William Haines
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden name: Hannah J. Harris
15. Birthplace: Cecil Co. Md.

16. Informant: Mrs Arline H. Cooper
Address: Charlestown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 2, 1946 (month) (day) (year)
Cemetery or crematory: Charlestown
Location: Charlestown, Md.
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Jan. 2, 19 46 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1945, at 7.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-17 1945, to Dec 30 1945 and that I last saw him alive on Dec-30 1945

Immediate cause of death	DURATION
Myocarditis	3 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. B. Collins M. D. or other
Address: North East, Md. Date signed 12-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12178

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 6 mo. 26 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Randolph
City or town: Kerens
(If outside city or towe limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. I ✓

3.(a) FULL NAME: HICKS, Don Z.

3.(b) Social Security Number: 232-22-5276

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): February 27, 1898

8. AGE: Years	Months	Days	If less than one day
47	9	15	— hrs. — min.

9. Birthplace: Kerens, W. Va. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12-13-45 (month) (day) (year)
Cemetery or crematory: Kerens Cemetery
Location: Kerens, W. Va.

18. Funeral director: Pennington & Son
Address: Havre d e Grace, Md.

19. Dec. 13, 19 45 (Date rec'd by registrar) Irene E. Dunlap Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12, 19 45, at 2:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 19 43, to December 12, 19 45
and that I last saw him alive on December 12, 19 45

Immediate cause of death	DURATION
Aneurysm, gastro-duodenal artery	1 yr. 9 Mo.
Due to: Arteriosclerosis, general and coronary	Undetermined
Other conditions: Psychosis with syphilis of the central nervous system, meningo-encephalitic type (Include pregnancy within 3 months of death)	over 2 yrs. 6 mo.

Major findings of operation: —
Date of op. —
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: A. E. HOLLINGER, Lt. Col., M.C. M. D. or other
Address: Veterans Administration, Perry Point, Md. Date signed: 12-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of age of deceased is shown on FILM No. G 99 DEC 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

12179

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 260 W Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Fannie Hopkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Joseph Hopkins
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 1 1871

8. AGE:	Years	Months	Days	If less than one day
74	73	11	3	hrs. min.

9. Birthplace: Port Deposit Cecil Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: no information
13. Birthplace: no information

MOTHER
14. Maiden name: no information
15. Birthplace: no information

16. Informant: Samuel Hopkins
Address: Elkton. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5 1945 (month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md

18. Funeral director: H W Pippin
Address: Elkton. Md

19. Dec 4 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R L Dodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Elkton Md Date signed: 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12180

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 95

1. PLACE OF DEATH:
County Ceil Co.
City or town Liberty Grove Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ceil Co Md,
City or town Liberty Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George I. Liddell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ella Liddell
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Jan 10 1871

8. AGE:

Years	Months	Days	If less than one day
74	11	19	hrs. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Thomas Liddell
13. Birthplace Scotland
MOTHER 14. Maiden name Julia Russell
15. Birthplace Scotland
16. Informant Ella Liddell
Address Liberty Grove Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 1 1946 (month) (day) (year)
Cemetery or crematory Hopewell
Location near Port Deposit Md.
18. Funeral director J. E. Tyson
Address Rising Sun, Md.
19. Dec 31 1945 (Date rec'd by registrar) Registrar

Permit issued 12-31-45

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945 at 5A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945 to Dec 29 1945
and that I last saw h[illegible] alive on Dec 29 1945

Immediate cause of death	DURATION
Cardio-Renal-Vascular	2 yrs
Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Geo B. Holcomb M.D.
M. D. or other
Address Rising Sun Md. Date signed Dec 30 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12181

Reg. Dist. No. 9v

1. PLACE OF DEATH:

County Cecil

City or town Rural (Elkton)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Rural (Elkton)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cowentown
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edna Martha Lofland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William Lofland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 28-1877 Maryland

8. AGE: Years	Months	Days	If less than one day
68	8	9	..... hrs. ..... min.

9. Birthplace Cecil, Maryland
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business General Store.

FATHER
12. Name Thomas Barbon
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Graham
15. Birthplace Maryland

16. Informant Mary Barr
Address Elkton R.D 3 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-10-45 (month) (day) (year)

Cemetery or crematory Harmony

Location Rowlandsville Md

18. Funeral director Florence E. Abernathy

Address Elkton R.D. 3 Md

19. Dec 8 19 45 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1945, at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1945 to Dec. 7 1945

and that I last saw h.er alive on Dec. 3 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Donald W. Spreadbury M.D.
M. D. or other

Address Elkton Md Date signed Dec. 8, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

12182

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, institution, or street address where death occurred: Church Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Cecilton R D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Eugene R Manlove

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Elsie Manlove
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 20 1864

8. AGE:

Years	Months	Days	If less than one day
81	7	1	hrs. min.

9. Birthplace: Cecilton Cecil maryland
(Town, county, and state)
10. Usual occupation: Farmer (retired)
11. Industry or business

FATHER
12. Name: Mark Manlove
13. Birthplace: Cecilton Md

MOTHER
14. Maiden name: Mary Ellen Conly
15. Birthplace: Cecilton Md

16. Informant: Mrs Bouchelle
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23 1945 (month) (day) (year)
Cemetery or crematory: Forest cemetery
Location: Middletown Delaware

16. Funeral director: H. W. Pippin
Address: Elkton, Md

19. Dec 27 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Dec 21 1945 and that I last saw h alive on December 15 1945

Immediate cause of death	DURATION
Carcinoma of skin	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. T. Morrison, M.D.
M. D. or other
Address: Elkton, Md Date signed 12-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

Burial 12183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A-15

1. PLACE OF DEATH:
County: Cecil
City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, institution, or street address where death occurred:
Elkton R.D. 5
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Catherine Maurer.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 10, 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	4	3		

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: John Burns
13. Birthplace: Germany.

MOTHER
14. Maiden name: No Information
15. Birthplace

16. Informant: Mrs Paul Arbaw
Address: Elkton R.D. 5, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16 45 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton, Md

18. Funeral director: H. W. Pepperis
Address: Elkton, Md

19. Dec 15 1945 (Date rec'd by registrar) H Brazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to Dec 13 1945
and that I last saw her alive on Dec 12 1945

Immediate cause of death	DURATION
Chronic Endocarditis	
Due to	
Due to	
Other conditions: General arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Herbert Bates M. D.
M. D. or other
Address: Elkton Md Date signed: 12/14/45

12184

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 95

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Cecil

City or town Rural - Colora

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Colora. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Blanche Mae McCauley

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Paul McCauley

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May. 3. 1900

8. AGE: Years	Months	Days	If less than one day
45	7	16	...hrs. ...min.

9. Birthplace Conowingo, (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name William Hill

13. Birthplace Conowingo. Md.

MOTHER

14. Maiden name Florence Hanna

15. Birthplace Conowingo. Md.

16. Informant William McCauley.

Address Colora. Md. R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23 1945 (month) (day) (year)

Cemetery or crematory Baptist Cemetery

Location Conowingo Md.

18. Funeral director J. E. Tyson.

Address Rising Sun Md.

19. Dec. 22. (Date received by registrar) 19 45 Lm Worthington Registrar

Permit issued 12-22-45

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-17 1945, to 12-19 1945

and that I last saw h alive on 12/19 1945

Immediate cause of death	DURATION
Lobar Pneumonia.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Dodgen M.D.

M. D. or other

Address Rising Sun Md. Date signed 12/20/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

12185

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
190 Hollingsworth Manor
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 190 Hollingsworth Manor.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Shirley Jean McCulley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4, 1943

8. AGE: Years	Months	Days	If less than one day
2	7		hrs. min.

9. Birthplace Cherry Hill, Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Ronald McCulley
13. Birthplace Knoxville Tenn

MOTHER
14. Maiden name Pauline McCraw
15. Birthplace Carroll Co, Va

16. Informant Mrs. Ronald McCulley
Address Elkton Md 190 Hollingsworth Manor.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Dec 6, 45
(month) (day) (year)

Cemetery or crematory Cherry Hill
Location Cherry Hill Md

18. Funeral director C. W. Pippin
Address Elkton, Md

19. Dec 5 1945
(Date rec'd by registrar)
F R Frazer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 1945, to December 4 1945
and that I last saw h[illegible] alive on December 4 1945

	DURATION
Immediate cause of death: Pernicious Anemia	3 weeks
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. Johnson M.D.
M. D. or other
Address 232 E. High St. Elkton Md Date signed 12/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

12186

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 Bells Lane
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baby McNeil

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 5 1945

8. AGE:

Years	Months	Days	If less than one day
		3	..... hrs. ..... min.

9. Birthplace: Elton, Cecil Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Jesse Rogers McNeil
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Earnestine Johnson
15. Birthplace: North Carolina

16. Informant: Jesse Rogers McNeil
Address: 111 Bells Lane, Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-10-1945 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Newark Del

18. Funeral director: Edw R. Bell

Address: 909 Poplar St. Wilm. Del.

19. Dec 10 1945 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1945 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5 1945 to Dec. 8 1945 and that I last saw h... alive on December 8 1945

Immediate cause of death	DURATION
Lobar pneumonia	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James L. Johnson M.D.
M. D. or other

Address: 202 E. High St, Elkton Md. Date signed: 12/10/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

12187

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15-1

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. RD 5

(If rural, give LOCATION)

2.(a) If veteran, name war: not a veteran

3. (a) FULL NAME: Thomas B. Miller

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Isabell Harlan Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 13 1865

8. AGE: Years	Months	Days	If less than one day
80	9		..... hrs. ..... min.

9. Birthplace: Cherry Hill, Md.

(Town, county, and state)

10. Usual occupation: Banker

11. Industry or business: Retired

FATHER 12. Name: Kennard Miller

FATHER 13. Birthplace: Md

MOTHER 14. Maiden name: Campbell

MOTHER 15. Birthplace: Maryland

16. Informant: Miss Mollie Harlan

Address: Elkton, RD Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-45 (month) (day) (year)

Cemetery or crematory: Cherry Hill Methodist

Location: Elkton Rural

18. Funeral director: Joseph R. Grant

Address: North East, Md

19. Dec 28 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1945 at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937, to Dec 25 1945

and that I last saw him alive on Dec 25 1945

Immediate cause of death	DURATION
Chronic Endocarditis	
Due to	
Due to	
Other conditions: Arthritis deformans	20 Years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wesley Kelly M. D.

M. D. or other

Address: Elkton Md Date signed 12/26/45

Frederick.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

12188

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton R D 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton R D 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Mills

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: James Mills
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): June 10. 1879

8. AGE: Years	Months	Days	If less than one day
66	6	2	hrs. min.

9. Birthplace: Lanchires England
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: no information
13. Birthplace: England

MOTHER
14. Maiden name: no information
15. Birthplace: England

16. Informant: James Mills
Address: Elkton Md R D 1

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec 16 1945
(month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md

18. Funeral director: H W Pippin & Son
Address: Elkton, Md

19. Dec 15 1945
(Date rec'd by registrar)
F R Frazer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 12, 1945, at 1:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 1945, to Dec 12 1945 and that I last saw her alive on Dec. 11, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	5-6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Pippin M. D. or other
Address: Elkton, Md. Date signed: Dec. 14, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

12189

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 1 wk

Hospital, institution, or street address where death occurred: Booth St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Booth St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Barclay Simpers Minor

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1944

8. AGE: Years	Months	Days	If less than one day
1	0	7	..... hrs. ..... min.

9. Birthplace: Elkton, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Harry B. Minor

13. Birthplace: Chesterfield, Va

MOTHER

14. Maiden name: Mary Simpers

15. Birthplace: Phila, Pa

16. Informant: Mrs. Mary Simpers Minor

Address: Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27/45 (month) (day) (year)

Cemetery or crematory: Elkton Col. Cemt

Location: Elkton, Md

18. Funeral director: H.W. Lapsley

Address: Elkton, Md

19. Dec 26 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1945 at 11:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 1945 to Dec. 21 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Bronchio-pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James L. Johnson M.D. M. D. or other

Address: Elkton, Md Date signed: 12/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12190

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 9 mos. 18 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Perry Point, Md.
How long in hospital or institution? 1 yr. 9 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Cumberland
City or town: Shippensburg
(If outside city or town limits, write RURAL and give nearest town).
Street No. 113 N. Earl St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: MINOR, Oscar O.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: //// Pauline Minor
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): March 2, 1895

8. AGE: Years	Months	Days	If less than one day
50	9	19	....hrs. --- ....min.

9. Birthplace: Hallton, Pa. (Town, county, and state)
10. Usual occupation: Oil Refinery
11. Industry or business: Oil

FATHER
12. Name: Shelton Minor
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Olive Gardner Minor
15. Birthplace: Pennsylvania

16. Informant: Records, Vets. Administration
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof December 22, 1945 (month) (day) (year)
Cemetery or crematory: Spring Hill Cemetery
Location: Shippensburg, Pa.
18. Funeral director: Pennington & Son
Address: PENNINGTON & SON Havre de Grace, Md.

19. Dec 22 19 45 Irma E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 19 45, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Huntingdon's Chorea	over 3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op. --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of --
Where did injury occur? --
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, LT.COL., MC, U.S.A. DIRECTOR
Address: Vets. Adm., Perry Point, Md. Date signed: 12-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

12191

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration Perry Point, Md.
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs. 3 mo. 4 days

Hospital, institution, or street address where death occurred:
Same as above Veterans Administration

How long in hospital or institution? Perry Point, Md. Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Piedmont
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war: W. W. I

3. (a) FULL NAME: NASEF, Shadeed

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	W

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1895 Month and day unknown

8. AGE:

Years	Months	Days	If less than one day
50	—	—	... hrs. ... min.

9. Birthplace: Syria (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) Dec. 27, 1945

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. (Date rec'd by registrar) Dec. 27 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1945, at 2:17 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 1923, to Dec. 23 1945 and that I last saw him alive on December 23, 1945

Immediate cause of death	DURATION
Myocardial Degeneration	Undetermined
Due to:	
Due to:	
Other conditions: Dementia Precox, Hebephrenic	Over 20 years

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: E. TROLLINGER, Lt. Col., M.C. M. D. or other

Address: Veterans Administration, Perry Point, Md. Clinical Director

Date signed: 12-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12192

Reg. Diat. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or towe limits, write RURAL aod give nearest town)
How long in above place of death? 1 yr. 5 mo. 11 days
Hospital, institution, or streel address where death occurred:
Vetdrans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Schroeder Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW 1

3. (a) FULL NAME: OFFER, Columbus

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: Estella Phillips
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	17	.....hrs. .....min.

9. Birthplace: Conowingo, Md.
(Town, county, and state)
10. Usual occupation: Stevedore
11. Industry or business: —

FATHER
12. Name: Richard Offer
13. Birthplace: Churchton, Md.

MOTHER
14. Maiden name: Mattie Steward
15. Birthplace: Churchton, Md.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-29-1945 (month) (day) (year)
Cemetery or crematory: Arbutus Cemetery
Location: Arbutus, Md.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Dec. 29 19 45 Irene E. Laughton Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 1945, at 6:00P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1944 19.. to Dec. 26 19 45 and that I last saw him alive on December 26 19 45

Immediate cause of death	DURATION
Syphilis of Central Nervous System,	
Meningo-encephalitic type	34 years
Due to: Abscess of right buttock	2 months
Due to: Arteriosclerosis, cerebral and	
general	Undetermined
Other conditions Psychosis with syphilis of Central Nervous System, Meningo-encephalitic type. (Include pregnancy within 3 months of death)	1½ yrs.

Major findings of operation: —
Date of op. —
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt. Col., M. C.
Clinical Director, Veterans Administration
M. D. or other
Address: Perry Point, Md. Date signed: 12-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

12193

★ Reg. Dist. No. 91

1. PLACE OF DEATH:

County: Cecil

City or town: Rural near Earleville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

Beaufort Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Near Embrella

(If ontside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Emma Osbourn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: Septimus F. Osbourn

B.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 26 1856

8. AGE: Years	Months	Days	If less than one day
89	4	5	____ hrs. ____ min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Music Teacher

11. Industry or business

FATHER — 12. Name: George Pestel

13. Birthplace: Germany

MOTHER — 14. Maiden name: Mary Snyder

15. Birthplace: Pa.

16. Informant: James S. Frazer

Address: Earleville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/46 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Cecil County

18. Funeral director: Earl Tyson

Address: Rising Sun, Md.

19. Jan 3 19 46 Lemmon Thurington (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/31 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1937 to Dec 31 1945 and that I last saw h... alive on Dec 10 1945

Immediate cause of death	DURATION
acute cardiac failure	min.
Due to chronic cardiovascular renal disease	10 years
Due to	
Other conditions: Found dead in bed.	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: H. Dorsey Mc M. D. or other

Address: Chesterhead Md. Date signed 12/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

12194

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Rowlandsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N. J. County: Monmouth

City or town: Asbury Park N. J.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Outerbridge

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

8.(b) Name of husband or wife: George Outerbridge

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 27. 1866

8. AGE: Years: 79 | Months: | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Lancaster Co. Pa.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Josephine Brown

Address: 51 N. Willow St. Mont Clair N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28 1945 (month) (day) (year)

Cemetery or crematory: Ost Bros

Location: Cornwells Md.

18. Funeral director: C. E. Tyson

Address: Rising Sun Md.

19. Dec 27 1945 Filed (Date rec'd by registrar) Dec 29 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1945, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1945, to Dec 26 1945, and that I last saw h[illegible] alive on Dec 25 1945.

	DURATION
Immediate cause of death:	
Chronic myocarditis	9-23-45
Due to:	
Due to:	
Other conditions: Intestinal ulcer	9-23-45

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Claude L. Dawson M. D. or other

Address: Havre de Grace Date signed: 12-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

CERTIFICATE OF DEATH

12195

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 7 mo. 11 das.
Hospital, institution, or street address where death occurred: Veterans Administration, Perry Point, Md.
How long in hospital or institution? 1 yr. 7 mo. 11 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Norfolk
City or town: Portsmouth
(If ontside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: PEDRICK, Samuel P.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 13, 1878

8. AGE: Years: 67 | Months: | Days: 11 | If less than one day: — hrs. — min.

9. Birthplace: Portsmouth, Va. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Charles W. Pedrick
13. Birthplace: Plymouth, N.C.

MOTHER
14. Maiden name: Mary Owens
15. Birthplace: Portsmouth, Va.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Grove Cemetery, Portsmouth, Va.
Location:

18. Funeral director: PENNINGTON & SON, Havre de Grace, Md.
Address:

19. Dec. 26, 1945 (Date rec'd by registrar) Irene E. Dauphin (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24, 1945, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1944, to December 24, 1945 and that I last saw him alive on December 24, 1945

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, bilateral	18 mo.
Due to: Arteriosclerosis, general and coronary, with occlusion,	Undetermined
Due to: Pleurisy with effusion,	10 da.
Due to: Pneumonia, terminal, Cholecystitis with cholelithiasis	2 da.
Other conditions: Dementia Precox, Paranoid Type	Undetermined Over 20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt. Col., M. C., U.S. Dr. or other
Director, Veterans Administration
Address: Perry Point, Md. Date signed: 12-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12200

Reg. Diat. No. 9V

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days.

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 33 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Roberta Perry.

3. (b) Social Security Number

4. Sex: F. | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Homer Perry.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7 1866

8. AGE: Years: 79 | Months: 8 | Days: | If less than one day: hrs. min.

9. Birthplace: Elkton, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Benj England.

13. Birthplace: Elkton Md.

MOTHER 14. Maiden name: Anna May Pierson

15. Birthplace: Calvert, Md.

16. Informant: Monroe Perry.

Address: Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11, 1945 (month) (day) (year)

Cemetery or crematory: Resubmit Cem.

Location: Calvert, Md.

18. Funeral director: Ralph M Reed

Address: Rising Sun md

19. Dec 11 1945 (Date rec'd by registrar) H B Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7 1945, at 7.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1945, to 12-7 1945, and that I last saw h.. alive on 12-7 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to Hemiplegia Right side.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H.H. Woodcock M.D. M. D. or other

Address: Rising Sun Md. Date signed: 12/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

12196

CERTIFICATE OF DEATH

Reg. Dist. No. 9-1

1. PLACE OF DEATH:

County Cecil

City or town Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillian M. Price

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Widowed

6.(b) Name of husband or wife Harry Price

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	28	..... hrs. ..... min.

9. Birthplace Chesapeake City, Md (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Robert Watson

13. Birthplace Chesapeake City, Md

MOTHER 14. Maiden name Henrietta Morgan

15. Birthplace Chesapeake City Md

16. Informant Thelma Imada

Address Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 26 1945 (month) (day) (year)

Cemetery or crematory Bethel

Location Near Chesapeake City, Md

18. Funeral director H. W. Lupfing

Address Elkton, Md

19. Dec 26 1945 (Date rec'd by registrar) Thos. Bayard D. Todd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1945, at 9 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1934 to Dec 21 1945 and that I last saw h alive on Dec 21 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	15 Minutes
Due to Chronic hypertension	
Due to Carcinoma bronchus disease	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. N. Davis M.D. M. D. or other

Address Chesapeake City Md Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12197

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: Union Hospital
How long in hospital or institution? 7 dys

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William T. Price

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White 2	~~widowed~~ Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22 - 1873

8. AGE: Years	Months	Days	If less than one day
72	3	6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
12. FATHER — Name: Washington Price
13. FATHER — Birthplace: ~~unknown~~ Cecil County
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace:
16. Informant: ~~The deceased~~ Father Informant
Address: Port Deposit
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11, 1945 (month) (day) (year)
Cemetery or crematory: Fairview
Location: Rt 1 Perryman, Md. Aberdeen
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Dec 10 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8 to 1945 at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1945, to Dec 8 1945 and that I last saw h. alive on Dec 8 1945

Immediate cause of death	DURATION
Acute cardiac dilatation	Suddenly
Due to: General Arterio-sclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. H. McKnight M.D. M. D. or other
Address: Elkton - Md. Date signed 12/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12201

FILM No. I 0 0 JAN 8 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 26 da., 10 mos.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? 1 yr. 26 da. 10 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 3
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: RIGGS, Harry B.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: Unknown - separated

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 3, 1895

8. AGE: Years	Months	Days	If less than one day
50 ~~45~~	9	18	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER
12. Name: John F. Riggs
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown - Mary Riggs
15. Birthplace: Maryland

16. Informant: Records - Veterans Administration

Address: Perry Point, Md. 1/8/24 ah

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-28-45 (month) (day) (year)

Cemetery or crematory: Norbeck

Location: Silver Springs, Md.

18. Funeral director: Pennington & Son

Address: PENNINGTON & SON, Havre de Grace, Md.

19. Dec. 29 1945 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25, 1944 to December 21 1945 and that I last saw him alive on December 21 1945

Immediate cause of death	DURATION
General Paralysis of the Insane	2yrs.
Due to	
Due to	
Other conditions: Psychosis w/syphilis of central nervous system, meningo-encephalitic type.	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, LT.COL., MC, M.D. together with DIRECTOR

Address: Vets. Adm., Perry Point, Md. Date signed 12-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12198

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emma J. Schroeder

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: William H. Schroeder
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Feb. 14, 1890
8. AGE: Years: 55 Months: 9 Days: 22 If less than one day: hrs. min.
9. Birthplace: Perryville Cecil, Md. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: William Davis
13. Birthplace: Md
MOTHER 14. Maiden name: Anna A Price
15. Birthplace: Md
16. Informant: William J. Schroeder
Address: Perryville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1945 (month) (day) (year)
Cemetery or crematory: Cokesbury
Location: Port Deposit Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Dec. 6 19 45 Irma E. Murphy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 1945 at 2 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2nd 1945 to Dec. 6 1945
and that I last saw h... alive on Dec. 1 1945

	DURATION
Immediate cause of death: Chronic Valvular Heart Disease	5 yrs
Due to:	
Due to:	
Other conditions: General Atheromata	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville, Md. Date signed: Dec. 6 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

12199

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil.

City or town: Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Girl Sturgill (Diana Kathryn)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1945

8. AGE:

Years	Months	Days	If less than one day
		6	..... hrs. ..... min.

9. Birthplace: Elkton, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: John Sturgill

FATHER — 13. Birthplace: North Carolina.

MOTHER — 14. Maiden name: Ann Lesick.

MOTHER — 15. Birthplace: Elkton, Md

16. Informant: John Sturgill

Address: Elkton, Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Dec. 11 45 (month) (day) (year)

Cemetery or crematory: Elkton Catholic

Location: Elkton, Md

18. Funeral director: H. W. Tippin

Address: Elkton, Md.

19. Dec 10 19 45 (Date rec'd by registrar) J R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 19 45, at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3 19 45 to Dec. 9 19 45

and that I last saw h[illegible] alive on Dec. 9 19 45

Immediate cause of death	DURATION
(a) Prematurity	
Due to (28 wk - premature)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr. W. Spence Lee, M.D. M. D. or other

Address: Elkton, Md Date signed Dec. 10

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12202

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9320)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 days.
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 43 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: ~~Elkton~~ North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret J. Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Charles E Thompson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 28 1874

8. AGE: Years	Months	Days	If less than one day
71	—	15	hrs. min.

9. Birthplace: North East Cecil Co. Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Richard Lewis
FATHER 13. Birthplace: Bound Brook, N. J.
MOTHER 14. Maiden name: Eliza Jane Abrams
MOTHER 15. Birthplace: Penn
16. Informant: Charles E Thompson
Address: North East (Rural) Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/16/45 (month) (day) (year)
Cemetery or crematory: Cemetery Elkton
Location: Rising Sun Rural
18. Funeral director: Joseph R Grant
Address: North East Md.
19. Dec 15 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 19 45 at 12 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-5 19 45 to 12-13 19 45
and that I last saw h.. alive on 12-12- 19 45

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	
Due to: Chronic Myocarditis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R L Dodson M.D. M. D. or other
Address: Rising Sun Md Date signed 12/13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

12243

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Colora

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Colora

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clay Watson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 17 45

8. AGE:

Years	Months	Days	If less than one day
0	0	17	..... hrs. ..... min.

9. Birthplace: Colora Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Bledsoe Watson

13. Birthplace: Alleghany Co N C.

MOTHER

14. Maiden name: Esther Anderson

15. Birthplace: Alleghany Co N C.

16. Informant: Bledsoe Watson

Address: Colora Maryland

17. (Burial, cremation, or removal. Which?) Date thereof Dec 8 45 (month) (day) (year)

Cemetery or crematory: Union Cemetery Alleghany Co N C

Location

18. Funeral director: H. S. Bailey

Address: Darlington, Md.

19. Dec 6 1945 (Date rec'd by registrar) H. S. Worthington Registrar

Permit issued 12-6-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 1945 to Dec 5 1945

and that I last saw h. alive on Dec 4 1945

Immediate cause of death: Premature birth at 7 months. Twins

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. G. Robinson M. D. M. D. or other

Address: Oxford, Penna. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1224 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Cecil
City or town Colora
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town Colora
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Ray Watson

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: No

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1945

8. AGE: Years | Months | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cecil Co., Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Bedgnal Watson
13. Birthplace: Allegheny Co., N.C.

MOTHER
14. Maiden name: Etta Anderson
15. Birthplace: Allegheny Co., N.C.

16. Informant: Bedgnal Watson
Address: Colora, Cecil Co., Md.

17. Baltimore (Burial, cremation, or removal. Which?) Date thereof Dec. 7, 1945 (month) (day) (year)
Cemetery or crematory: Union Cem
Location: Allegheny Co., N.C.

18. Funeral director: H. B. Bailey
Address: Darlington, Md.

19. ..... 19..... Registrar
(Date rec'd by registrar)

Permit issued Dec 4-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 4 19 45, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Premature at seven months one of twins.

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. B. Robinson M.D.
M. D. or other
Address: Oakland Penna. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

12205

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CECIL

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 1 mo. 6 da.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2121 E. Fairmount Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War ✓

3.(a) FULL NAME: WEATHERS, Clarence H.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~////~~ Mrs. Annie L. (Maiden name unknown) 6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 7-17-1880

8. AGE:

Years	Months	Days	If less than one day
65	4	26	....hrs. ....min.

8. Birthplace: Raleigh, N.C. (Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records, Veterans Administration, Perry Point, Md.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: December 13, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Dec. 13 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 19 45 10:42 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7, 1940 19 ..., to December 13 19 45 and that I last saw him alive on December 13 19 45

Immediate cause of death	DURATION
Chronic Glomerular Nephritis	Undetermined
Due to: ~~xxxx~~ Arteriosclerosis, generalized and coronary	5 yrs.
Due to: ~~xxxx~~ Ulcerative colitis	Undetermined
Other conditions: Psychosis with cerebral arteriosclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op. —

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Rollinger

Address: A. E. ROLLINGER, Lt. Col., M.C., CO Director, Veterans Administration, Perry Point, Md. Date signed: 12-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

12206

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ellen May Wesley.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Married

6.(b) Name of husband or wife: Arthur C. Wesley.
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): June 23 1890

8. AGE: Years: 55 | Months: 5 | Days: 12. | If less than one day: hrs. min.

9. Birthplace: Elkton Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Brooks.
13. Birthplace: Pa.

MOTHER
14. Maiden name: Lula Richardson
15. Birthplace: Elkton Md

16. Informant: Arthur C. Wesley
Address: Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-9-45 (month) (day) (year)

Cemetery or crematory: CEDAR HILL
Location: ELKTON RURAL

18. Funeral director: Joseph R. Hamm
Address: North Easy Md

19. Dec 7 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 18..... to ..... 19.....
and that I last saw h..... alive on ..... 18.....

	DURATION
Immediate cause of death	
Acute Coronary Thrombosis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Elkton Md. Date signed 12-6-45

(M) (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

12207

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lillian Dracy White.

3. (b) Social Security Number

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Walter W. White
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feb. 6, 1881
8. AGE: Years: 64 Months: 10 Days: 11 If less than one day ..... hrs. ..... min.
9. Birthplace: Hames Quarter, Somerset Co. Md (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business:
FATHER 12. Name: James A. Todd
13. Birthplace: Somerset Co., Md
MOTHER 14. Maiden name: Emily W. White
15. Birthplace: Somerset Co., Md
16. Informant: Walter W. White Sr.
Address: Perryville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20, 1945 (month) (day) (year)
Cemetery or crematory: Principio
Location: Principio Furnace, Md.
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Dec. 19 1945 Irma E. Douglas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17th 1945, at 1:30 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 8 1939, to Dec. 17 1945
and that I last saw h. alive on Dec. 17 1945

	DURATION
Immediate cause of death: Cerebral Haemorrhage	1 da
Due to:	
Due to:	
Other conditions: Cerebral Haemorrhage with Paralysis right side	7½ yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville Md Date signed 1/7/1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (65)

CERTIFICATE OF DEATH

12208

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 6 mo. 13 days.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State: Md. County: —

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I ✓

3.(a) FULL NAME: WIELEWSKI, (Wielekowski) Waclaw

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 18, 1897

8. AGE: Years	Months	Days	If less than one day
48	1	24	— hrs. — min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Tinsmith

11. Industry or business: —

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Poland

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: December 14, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son

Address: Pennington & Son, Havre de Grace, Maryland

19. Dec. 14 19 45 Irene E. Daughaday
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 45 at 10:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 19 42, to December 12 1945 and that I last saw him alive on December 12 19 45

Immediate cause of death	DURATION
Disease of the Adrenals (Addison's Disease)	Over 3 months
Due to: Pneumonia, terminal	2 days
Due to:	
Other conditions: Dementia Precox, Mixed Type	6½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A.E. Rollinger

A.E. ROLLINGER, Lt.Col., M.C. (M.D. or other)
Director, Veterans Administration
Address: Perry Point, Md. Date signed: 12-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING